

TO: GINNY PERLIS
SENIOR NETWORK SERVICES MANAGER
PROVIDER RELATIONS

FROM: ETTA HAWKINS, R.PH.
MEDICAID PHARMACY PROGRAM MANAGER

RE: MEDICAID-PEACHCARE
COS 430, 431 470

DATE: NOVEMBER 3, 2003

DEAR PHYSICIANS:

Quantity Level Limits effective 1/1/2004:

Aranesp-

- QLL of (4) vials or/and syringes (in any combination) per calendar month. Overrides can be requested by contacting ESI at 1-877-239-2915. Override requests that are denied will require a 2nd level written appeal to DCH.

Temodar-

- QLL of (10) capsules per strength, per calendar month. Override requests require a 2nd level written appeal to DCH.

PA effective 1/1/2004:

Insulin Pen PA Criteria-

- Prior approval will be required for obtaining any insulin “pen” delivery system (Novopen, B&D Pen etc) and the corresponding insulin cartridges. A member may **not** obtain both insulin vials **AND** an insulin pen delivery system with insulin cartridges. All denials require a written 2nd level appeal to DCH.

Of Note:

It has come to the attention of the Department that there are detail pieces in the marketplace that name Fosamax as the “exclusive” bisphosphonate for GDCH. GDCH would like to clarify that although Fosamax is currently a preferred agent in this class categorized as a biphosphonates, Actonel is also available for the non-preferred co-payment.

PLEASE SHARE THIS INFORMATION WITH APPROPRIATE STAFF. IF YOU ARE THE CORPORATE OFFICE OF A CHAIN PHARMACY, PLEASE PROVIDE THIS

INFORMATION TO EACH OF YOUR STORES LOCATED IN GEORGIA. IF YOU HAVE
ADDITIONAL QUESTIONS OR CONCERNS REGARDING THIS NOTIFICATION,
PLEASE CONTACT ETTA HAWKINS, OR PAT ZEIGLER-JETER AT (404) 656-4044.

SINCERELY,

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE